

**APPENDIX B. MEDCASE/SUPERCEEP FORMS:
DA FORM 5027-R (MPR), DA FORM 5028-R (MSTF)**

B-1. INTRODUCTION

The basic MEDCASE/SuperCEEP forms, DA Form 5027-R (MPR) and DA Form 5028-R (MSTF) are the primary forms used to identify and obtain approval for MEDCASE/SuperCEEP eligible equipment items.

B-2. GENERAL

A MEDCASE/SuperCEEP requirement is initiated by the preparation and processing of DA Form 5027-R and DA Form 5028-R. Together they provide an auditable record that documents the need, coordination, and approval of a MEDCASE/SuperCEEP requirement. Chapter 3 contains guidance concerning the development and staffing of these forms.

B-3. REPRODUCTION

DA Form 5027-R and DA Form 5028-R will be locally reproduced on 8½ by 11 inch-paper. Copies for reproduction purposes are located at the back of this publication.

B-4. ELECTRONIC FORMS

DA Forms 5027-R and 5028-R are available electronically through the electronics forms library of the U.S. Army Publishing Directorate, Alexandria, VA.

B-5. PREPARATION

A DA Form 5027-R/5028-R must be prepared for each MEDCASE/SuperCEEP requirement, not recommended by the TARA, i.e., one DA Form 5027-R/5028-R for each end item, set, or system requested. Exceptions are discussed in chapter 3, of this bulletin. Provide the number of copies prescribed by command guidance. Forward complete copies of the DA Form 5027-R/5028-R with all enclosures to the address below.

U.S. Army Medical Materiel Agency
ATTN: MCMR-MMO-AT
1423 Sultan Drive, Suite 100
Fort Detrick MD 21702-5001

Copies that are forwarded should bear original signatures.

B-6. INSTRUCTIONS FOR COMPLETING DA FORM 5027-R, MEDCASE PROGRAM REQUIREMENT

MEDCASE PROGRAM REQUIREMENT			1. DATE (YYYYMMDD)	
For use of this form, see SB 8-75 MEDCASE; the proponent agency is the OTSG				
2. ACTIVITY (Name and Address)		3. FROM (Div, Dept or Svc)		4. ASSET CONTROL NUMBER
5. TDA-UIC	6. HAND RECPT CODE	7. BUDGET LINE ITEM CODE		
8. REQUIREMENT SUBMISSION <input type="checkbox"/> NEW (1 st Submission) <input type="checkbox"/> RESUBMISSION		9. POINT OF CONTACT		10. PHONE NUMBER
11. STANDARD ITEM DESCRIPTION OR GENERIC NOMENCLATURE (See SB 8-75 MEDCASE)				
12. EXTENDED SYSTEM DESCRIPTION		13. QUANTITY	14. UNIT PRICE	
15. JUSTIFICATION				
15a. HOW IS THE FUNCTION NOW BEING ACCOMPLISHED?				
15b. WHY IS THIS EQUIPMENT REQUIRED? (Workload data, new technology, cost reduction, maintenance costs, equipment down time or nonavailability, obsolescence of current methods, etc.)				
15c. IMPACT IF EQUIPMENT IS NOT PROVIDED				
16. ARE PERSONNEL ASSIGNED AND TRAINED TO OPERATE EQUIPMENT? (If No, explain)				
<input type="checkbox"/> YES <input type="checkbox"/> NO				
17. SPECIAL EQUIPMENT CATEGORY				
<input type="checkbox"/> FOR NEW OR RENOVATED FACILITY (BLIC NF) <input type="checkbox"/> CLINICAL INVESTIGATION PROGRAM (BLIC CP)				
<input type="checkbox"/> FOR NEW OR RENOVATED FACILITY (BLIC MB) <input type="checkbox"/> POLLUTION CONTROL PROGRAM (BLIC PC)				
<input type="checkbox"/> DRUG ABUSE/CONTROL PROGRAM (BLIC DA)				
<input type="checkbox"/> REPLACE, MODERNIZE, OR ACQUIRE EQUIPMENT FOR EXISTING FACILITY (BLIC UR)				
<input type="checkbox"/> REPLACEMENT NORMAL <input type="checkbox"/> REPLACEMENT ACCELERATED <input type="checkbox"/> NEW MISSION <input type="checkbox"/> MODERNIZATION				
<input type="checkbox"/> OTHER <input type="checkbox"/> UPGRADE <input type="checkbox"/> EXCESS <input type="checkbox"/> LEASE				
18. ITEM BEING REPLACED? <input type="checkbox"/> YES <input type="checkbox"/> NO	19. NSN/MCN	20. MMCN	21. SERIAL NUMBER	
22. MODEL NUMBER	23. LOCATION	24. DISPOSITION <input type="checkbox"/> RETAIN AS BACK-UP <input type="checkbox"/> TURN IN AS EXCESS <input type="checkbox"/> TRADE IN		
25. I CERTIFY THE INFORMATION ON THIS PAGE IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE				
25a. TYPED NAME AND TITLE OF REQUESTOR		25b. SIGNATURE		
26. THIS EQUIPMENT IS NECESSARY FOR THE ACCOMPLISHMENT OF THIS ACTIVITY'S MISSION.				
26a. TYPED NAME AND TITLE OF CHIEF OF DIV/DEPT/SVC		26b. SIGNATURE		

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Item 1 - Self-explanatory

Item 2 - Enter requesting activity name and address

Item 3 - Enter requesting Division, Department or Service

Item 4 - Enter appropriate Asset Control Number (see chapter 3)

Item 5 - Enter requesting activity TDA Unit Identification Code (UIC)

Item 6 - Self-explanatory

Item 7 - Enter applicable Budget Line Item Code (see chapter 3)

Items 8, 9 and 10 - Self-explanatory

Item 11 - Enter Standard Item Description (see appendix A)

Items 12, 13, and 14 - Self-explanatory

Items 15 and 16 - Self explanatory; continuation sheets may be used where necessary and it is acceptable to leave this item blank with a reference to "see attached sheet."

Items 17, 18, 19, 20, 21, 22, 23, and 24 - Self-explanatory

Items 25, and 26 - Self-explanatory. The initiator and the chief of the requesting department or service must sign this form to certify the requirement described is valid and that the justification provided is accurate to the best of their knowledge. Their signatures also certify that consideration has been given to the availability of existing and excess assets to satisfy the requirement.

B-7. INSTRUCTIONS FOR COMPLETING DA FORM 5028-R, MEDCASE SUPPORT AND TRANSMITTAL FORM

MEDCASE SUPPORT AND TRANSMITTAL FORM			
For use of this form, see SB 8-75 MEDCASE; the proponent agency is the OTSG			
1. ACTIVITY		2. ASSET CONTROL NUMBER	
EQUIPMENT MAINTENANCE ACTIVITY			
3. DO YOU SEE PROBLEMS WITH PROVIDING MAINTENANCE SUPPORT? (<i>If Yes, explain</i>)			
<input type="checkbox"/> YES <input type="checkbox"/> NO			
4. MAINTENANCE WILL BE PROVIDED		5. ANNUAL MAINTENANCE COST	
<input type="checkbox"/> IN-HOUSE <input type="checkbox"/> SERVICE CONTRACT		<input type="checkbox"/> NONE <input type="checkbox"/> ONE TIME <input type="checkbox"/> RECURRING	
7. REPLACED ITEM WITH MAKE AND MODEL			
8. LIFE EXPECTANCY (<i>Years</i>)		9. DATE IN SERVICE (<i>MM/DD/YY</i>)	
10. MCEL COST		11. EXPENDED COST	
12. EQUIPMENT AND INSTALLATION CHARACTERISTICS		13. THE JUSTIFICATION PROVIDED HAS BEEN REVIEWED AND THE STATEMENTS REGARDING MAINTENANCE HAVE BEEN VERIFIED.	
<input type="checkbox"/> REQUIRES INSTALLATION <input type="checkbox"/> COMPLEX <input type="checkbox"/> ROUTINE		THE REPLACEMENT OF THE ITEM <input type="checkbox"/> IS	
<input type="checkbox"/> REQUIRES TURNKEY INSTALLATION		<input type="checkbox"/> IS NOT SUPPORTED	
<input type="checkbox"/> EXISTING EQUIPMENT REQUIRES DEINSTALLATION		BASED UPON MAINTENANCE CONSIDERATIONS.	
<input type="checkbox"/> ADDITIONAL ELECTRICAL SUPPORT OR EMERGENCY POWER			
14. TYPED NAME AND TITLE OF REVIEWING OFFICIAL		15. SIGNATURE	
ENGINEER (<i>Health Facility Project Officer for BLIC NF & MB</i>)			
16. ARE SITE MODIFICATIONS, UTILITIES OR OTHER COSTS INVOLVED?		17. ESTIMATED SITE PREPARATION COSTS	
<input type="checkbox"/> YES <input type="checkbox"/> NO		<input type="checkbox"/> YES <input type="checkbox"/> NO	
18. WITHIN THE SCOPE OF THE PROJECT (BLIC NF OR MB)?			
19. TYPED NAME AND TITLE OF REVIEWING OFFICIAL		20. SIGNATURE	
INFORMATION MANAGEMENT OFFICER			
21. I HAVE REVIEWED THIS DOCUMENT AND RECOMMEND			
<input type="checkbox"/> APPROVAL <input type="checkbox"/> DISAPPROVAL <input type="checkbox"/> N/A			
22. TYPED NAME AND TITLE OF REVIEWING OFFICIAL		23. SIGNATURE	
RESOURCES MANAGEMENT OFFICER			
24. NON-MEDCASE COSTS ASSOCIATED WITH THIS REQUIREMENT ARE WITHIN CURRENT OR ANTICIPATED RESOURCES OF THIS ACTIVITY?		25. THE ECONOMIC CONSIDERATIONS CITED (<i>In Justification</i>) HAVE BEEN VERIFIED AND ARE ACCURATE?	
<input type="checkbox"/> YES <input type="checkbox"/> NO		<input type="checkbox"/> YES <input type="checkbox"/> NO	
26. TYPED NAME AND TITLE OF REVIEWING OFFICIAL		27. SIGNATURE	
RADIOLOGY REVIEW			
28. I HAVE REVIEWED THIS DOCUMENT AND RECOMMEND (<i>Comments attached</i>)			
<input type="checkbox"/> APPROVAL <input type="checkbox"/> DISAPPROVAL			
29. TYPED NAME AND TITLE OF REVIEWING OFFICIAL		30. SIGNATURE	
LOGISTICS REVIEW			
31. I HAVE REVIEWED THIS REQUEST AND RECOMMEND			
<input type="checkbox"/> APPROVAL <input type="checkbox"/> DISAPPROVAL			
I CERTIFY THIS REQUEST IS COMPLETE AND ACCURATE TO THE BEST OF MY KNOWLEDGE. REQUESTED EQUIPMENT IS ELIGIBLE FOR MEDCASE ACQUISITION.			
32. TYPED NAME OF LOGISTICS CHIEF		33. SIGNATURE OF LOGISTICS CHIEF	
ACTIVITY COMMANDER REVIEW			
34. I HAVE REVIEWED THIS REQUEST AND RECOMMEND		35. EQUIPMENT REPLACED WILL BE	
<input type="checkbox"/> APPROVAL <input type="checkbox"/> DISAPPROVAL		<input type="checkbox"/> TURNED IN <input type="checkbox"/> RETAINED <input type="checkbox"/> N/A	
36. TYPED NAME OF ACTIVITY COMMANDER		37. SIGNATURE OF ACTIVITY COMMANDER	
REGIONAL MEDICAL COMMAND (RMC) REVIEW			
38. I HAVE REVIEWED THIS DOCUMENT AND RECOMMEND		39. RMC CONSULTANT ACTION CODE	
<input type="checkbox"/> APPROVAL <input type="checkbox"/> DISAPPROVAL			
40. TYPED NAME OF RMC COMMANDER		41. SIGNATURE OF RMC COMMANDER	

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Items 1 and 2 - Self-explanatory (perpetuated from associated DA Form 5027-R)

Items 3 through 41 - Self-explanatory